STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE COMMISSIONER OF HEALTH

In the Matter of Caledonia Care and Rehab;
Extended Survey Exit August 28, 2009

RECOMMENDED DECISION

The above matter was the subject of an Independent Informal Dispute Resolution Conference (IIDR) conducted by Administrative Law Judge Manuel J. Cervantes (ALJ) on December 8, 2009. The OAH record closed at the conclusion of the conference that day.

Marci Martinson, IIDR Coordinator, Licensing and Certification Program, and Mary Cahill, Planner Principal, appeared on behalf of the Department of Health's Division of Compliance Monitoring (Department).

Marian Rauk, Assistant Administrator/Director of Nursing, Diane Lager, Human Resources, and Amy Schroeder, Social Worker, appeared on behalf of Caledonia Care and Rehab (Facility).

The Conference was conducted by telephone. The Department's representatives and ALJ were in a courtroom at the Office of Administrative Hearings in St. Paul. The representatives of Caledonia Care and Rehab were in their office in Caledonia.

FINDINGS OF FACT

1. In August 2009, the Department of Health conducted an extended survey at Caledonia Care and Rehab located in Caledonia, Minnesota.

2. The Division issued a Summary Statement of Deficiencies to the Facility following the extended survey exit August 28, 2009, citing a number of violations.[1]

3. The Facility disputes only one tag: Tag F323, in this IIDR proceeding.[2] Specifically, the Facility requests that the severity level be reduced from Level 4

[1] MDH Ex. F.
[2] 42 CFR 483.25(H) (1) and (2); (Accidents and Supervision; a facility must ensure that the resident environment remains as free from accidents as is possible and each resident receives adequate supervision and assistance devices to prevent accidents.); MDH Ex. E-1.

"Immediate jeopardy to resident health and safety" to Level 2 "No actual harm with potential for more than minimal harm that is not immediate jeopardy."[3]

Resident #8

4. Resident was admitted to the Facility on May 20, 2009. He had diagnoses that included Alzheimer's disease, depression, a history of falls, moderately impaired decision-making, and wandering behavior. The physician documentation of May 21, 2009, indicated Resident was uncooperative with staff, refused to sleep at night, was declining in status, and experienced worsening behaviors which resulted in the emergency admission to the Facility. Resident had previously resided in a hospital memory care unit until the emergency admission.[4]

5. An entry in Resident's care plan indicated that he was an "identified wanderer" and directed Facility staff to 1) know his whereabouts; 2) attempt to divert and redirect him; 3) report episodes of wandering; 4) establish routines; 5) notify doctors as needed; 6) have photo identification available on his chart; 7) place wander band on right ankle and check placement thereof every shift; 8) assure ability to identify Resident; and 9) determine a pattern to Resident's wandering.[5]

6. Resident's care plan did not identify the Resident as an elopement risk. Neither did the care plan provide staff with approaches to divert or redirect the Resident, or include a response protocol if the resident should leave the building or remove the wander band.[6]

7. Resident wandered throughout the Facility, wandered into other residents rooms, repeatedly questioned how to get out of the Facility, and how to get to Brooklyn Park, the location of his former residence. Facility staff indicated that Resident would frequently attempt to leave the Facility.[7]

8. On July 1, 2009, Resident was found in the kitchen in the lower level of the Facility looking for a way out of the building to go home. A wander band was placed on his ankle.[8]

9. Also, on July 1, 2009, the Facility completed an Elopement Risk Assessment. Resident's assessment included a diagnosis of dementia, independent mobility, wandering in the Facility, exhibiting signs of sundown syndrome, history of elopement, arrived from a secure memory unit, and not accepting of the nursing home placement. The care plan was to monitor Resident's whereabouts, use a wander guard bracelet, involve Resident in activities, and redirect Resident.[9]

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[3] Facility Reply, p. 1, Facility Letter of 9/25/09 to MDH.
[4] MDH Ex. F-4.
[5] *Id.*
[6] *Id.*
[7] MDH Ex. F-5.
[8] *Id.*
[9] MDH Ex. F-8.

10. On July 2, 2009, Resident attempted to find his way out of the Facility so he could walk to Minneapolis. At 7:20 p.m., Resident left the Facility via the west wing doors. An alarm on the doors sounded and Resident was retrieved by staff. Resident attempted to leave via the west wing doors again at 8:30 p.m.[10]

11. On July 4, 2009, Resident tried to go out the west wing doors, setting off the alarms.[11] Resident was assisted back into the building.

12. At approximately 5:00 p.m., on July 11, 2009, Resident eloped out the west exit with a Facility visitor. The alarm went off and Resident was found by staff in the west parking lot. Staff then took Resident for a short walk to a nearby school. Resident was assisted back into the building with the help of four staff members and police because of Resident's resistive behavior in returning to the Facility.[12]

13. At approximately 1:45 p.m., on July 25, 2009, Resident eloped when visitors were holding the door open in order to bring items into the Facility. The alarm sounded and staff observed Resident walking on the front side walk. Approximately 45 minutes later, Resident eloped again when he walked through a door that was ajar. The alarm sounded again. He was escorted back into the Facility with three staff members and a visitor. Resident sounded the alarm a total of four times on July 25, 2009.[13]

14. On July 30, 2009, Resident pushed his way through the south exit when staff opened the door. There was no wander guard alarm at this exit, but staff accompanied him outside to a bench before returning him to the Facility. Resident's physician was notified of the elopement.[14]

15. On August 5, 2009, Resident sounded the alarm while he was banging on the door to go outside.[15]

16. On August 11, 2009, Resident refused to let a staff member leave the Facility after duty unless the staff member took Resident home with her. Two additional staff members intervened to block Resident's path, permitting the detained staff member to leave.[16]

17. On August 23, 2009, Resident attempted to exit the Facility with a visitor. The alarm sounded and Resident was assisted back into the building.[17]

18. At approximately 6:30 p.m., on August 24, 2009, Resident was observed by a surveyor wandering throughout the building. Resident would state that he was a

[10] MDH Ex. F-6; Facility Ex. 1.
[11] *Id.*; Fac. Ex. 2.
[12] *Id.*; Fac. Ex. 3.
[13] *Id.*; Fac. Ex. 4.
[14] MDH Ex. F-7; Fac. Ex. 6.
[15] *Id.*; Fac. Ex. 7.
[16] *Id.*; Fac. Ex. 8.
[17] *Id.*

prisoner in the Facility, complained of being locked in, and often asked to leave the Facility.[18]

19. At 4:45 p.m., on August 26, 2009,[19] Division surveyors entered the south hall from the outside through the south Facility door. Resident #8 resides on the south wing. There is no wander guard alarm on the south door; rather, the door is equipped with a keypad which Resident is incapable of operating. The surveyor's entry triggered the alarm. Facility staff entered the south hall but did not walk down the hallway immediately to deactivate the alarm.[20] A Facility staff member had previously assisted the surveyors in exiting the Facility. So when she saw the surveyors set off the alarm when they reentered minutes later, she did not respond to the alarm but continued to administer medications to the residents.[21]

20. Two minutes later, a second staff member, DCP-F walked down the hallway and deactivated the alarm. DCP-F proceeded to the end of the hall where the door was located and peered out the door window. She saw a visitor smoking a cigarette on the patio. DCP-F did not open the door nor exit outside. DCP-F commented to a surveyor that a family member must have gone out the door.[22] DCP-F then proceeded in the opposite direction down the hall to Resident #8's room; where he was found sleeping.[23]

21. Based on interviews and record review, at 11:00 a.m. on August 27, 2009, the Division concluded that the Facility failed to ensure that the resident environment remained free from accidents and did not ensure that each resident received adequate supervision and assistance devices to prevent accidents. Based on these findings, the Division issued Tag F323 at severity level 4 (immediate jeopardy), isolated scope alleging a violation of 42 C.F.R. § 483.25(h).[24]

22. On August 27, 2009, the Facility acknowledged that it did not perform a comprehensive assessment of Resident #8's elopement risk.[25]

23. At 8:45 a.m. on August 28, 2009, the Facility's Elopement Plan was accepted by the Division. The Facility's immediate jeopardy status was removed at 9:05 a.m. the same morning.

24. The Plan included the following:

- all direct care staff are required to read the new door policy on how to respond to door alarms;

[18] MDH Ex. F-3.
[19] MDH Ex. F-9; the Division characterized this event as having occurred on 8/25/09.
[20] MDH Ex. F-9.
[21] Fac. Ltr. of 9/25/09 to MDH.
[22] MDH Ex. F-9.
[23] Fac. Ltr. of 9/25/09 to MDH.
[24] MDH Ex. F-3.
[25] MDH Ex. F-8.

- signage was posted on the south and east entrances to inform families and friends of residents that these are not main entrances to the building;

- a letter was delivered to the families of residents informing them of the need to enter through the main elevator and west entrances;

- if Resident #8 removes the wander band and will not allow its replacement, Facility staff will monitor him from close proximity and re-approach Resident with small frequent interventions until the wander band is replaced;[26]

- if Resident #8 removes a zip tie wander band, it will be replaced with a co-tag sewn into a pocket below the knee in a pant leg and pajamas;[27] and

- unobservable rooms will be locked and will be equipped with a magnetic key holder on the doorframe for staff's use when the door needs to be opened.[28]

25. On September 25, 2009, the Facility requested an IIDR review of the severity level 4 and requested that it be reduced to level 2.[29]

Based upon the exhibits submitted and the arguments made and for the reasons set out in the Memorandum that follows, the Administrative Law Judge makes the following:

RECOMMENDED FINDING AND DECISION

The severity level of Tag F 323 is not supported by the facts and should not be affirmed.

Dated: December 22, 2009

s/Manuel J. Cervantes
MANUEL J. CERVANTES
Administrative Law Judge

Reported: Digitally recorded (no transcript prepared).

[26] MDH Ex. F-9.
[27] MDH Ex. F-7.
[28] MDH Ex. F-4.
[29] Fac. Ltr. of 9/25/09 to MDH.

NOTICE

In accordance with Minn. Stat. § 144A.10, subd.16(d)(6), this recommended decision is not binding on the Commissioner of Health. As set forth in the Department of Health Information Bulletin 04-07, the Commissioner must mail a final decision to the Facility indicating whether or not the Commissioner accepts or rejects the recommended decision of the Administrative Law Judge within 10 calendar days of receipt of this recommended decision.

MEMORANDUM

The Division issued Tag F323 at severity level 4, immediate jeopardy, isolated scope. The facility does not challenge the finding that its practices were deficient because it did not have a comprehensive Facility Elopement Plan in place on the date of the citation. The Facility does, however, challenge whether this deficiency warranted a determination of immediate jeopardy. Instead, the Facility argues that a severity level 2 representing "[n]o actual harm with potential for more than minimal harm that is not immediate jeopardy" is more appropriate in this case.[30]

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.[31] The facility must ensure that the resident environment remains as free from accident hazards as is possible and that each resident receives adequate supervision and assistance devices to prevent accidents.[32] The intent of this provision is to ensure that the facility provides an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents.[33]

Immediate jeopardy is interpreted as a crisis situation in which the health and safety of individuals are at risk (*see* State Operations Manual §3010). Immediate jeopardy is defined as "[a] situation in which a provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident."[34] Serious harm, injury, impairment, or death does not have to occur before considering immediate jeopardy. The high potential for these outcomes to occur in the very near future also constitutes immediate jeopardy.[35]

Of the dozen or so attempted elopements, Resident #8 managed to exit through the Facility's doors approximately six times over the course of about three months. On each of these occasions, staff responded immediately. At no time did Resident #8 leave the Facility grounds. In all cases, except the one occasion when Resident pushed

[30] MHD Ex. C-4.
[31] 42 C.F.R. § 483.25.
[32] 42 C.F.R. § 483.25 (h)(1) & (2).
[33] MHD Ex. E-1.
[34] MHD Ex. D-2.
[35] MHD Ex. D-3.

his way out, and over a staff member, the wander guard alarms were activated. On every occasion, staff assisted Resident #8 back into the building without any harm.

There is no wander guard on the south exit, but staff was present when Resident #8 pushed his way through. On this occasion, Staff exited with Resident #8 and they sat together on a bench until Resident became cold. Staff assisted Resident back into the Facility a short time later.[36]

What appears to have triggered the immediate jeopardy finding was the event that occurred on August 26, 09; the two minute delay in Facility staff responding to an alarm at the south wing. A two minute delay in responding to a door alarm can lead to serious resident health and safety consequences.

However, as indicated above, the same staff person who assisted the surveyors in exiting the south wing doors by deactivating the alarm, witnessed their reentry a few minutes later and knew it was the surveyors who triggered the alarm, not a resident. She did not respond to the alarm, but continued to administer resident medications. The second staff member, DCP-F who appeared two minutes later, deactivated the alarm and proceeded to Resident #8's room, after seeing a visitor smoking on the south patio through a window. DCP-F confirmed that Resident #8 was in his room.

Under these circumstances, neither Resident #8, nor any other resident was in an immediate jeopardy situation rising to a level of crisis.

The facility acknowledged that a comprehensive elopement plan was required and therefore, a deficiency is admitted, but under the circumstances described above, the ALJ cannot see a high potential for serious harm or death and therefore, the deficiency rises only to a severity level 2.

M. J. C.

[36] Fac. Ex. 6.